FAQ from Atypcial Conversion Webinar 4/15/13

CDAC	
So if a person is getting Daily CDAC we can change it NOW to 24hrs/day and 31 days/mo and enter 744hrs/month into the plan, and it will be approved?	No, this would not be approved. There is not enough funding in most waivers for (24 X 31 X 7.25) = $5394.00 per month. You must take into consideration how many hours of CDAC were used to create the daily agreement.
	What you can do now is work with the provider and member to convert to a 15 minute unit at $1.81 per unit (assuming minimum wage of $7.25). Convert back up to hourly CDAC for the time period until 7/1/13. If the hourly units are approved in ISIS before 5/1/13 then the IME will convert back down to 15 minute units.
If a CDAC provider has a billing question on the new way to bill; who would they contact to get assistance to bill correctly?	Providers can contact their case manager or service worker, or they can contact the IME Provider Services unit at 800-338-7909 option 3 or 256-4609 option 3.
Will CDAC providers receive instructions on how to enter the new information on their claim forms? Have Individual CDAC providers been informed of the code changes and will training be provided for them? Are you going to send out letters to Individual CDAC providers of this change?	CDAC providers have been included in all communications regarding this project. In addition, the IME Provider Services unit has already undertaken communications directed to the individual CDAC providers. An individual CDAC provider communication plan will be implemented by the IME over the next several months.
Will training be provided for CDAC providers locally about the conversions and documentation before implementation?	At this time, there is no on-site training planned for individual CDAC providers. There is no change in documentation; providers will continue to document per directions from the IME.
Will that notification report of conversion changes go to individual CDAC providers as well?	Yes, individual CDAC providers will receive the same notification report as all other HCBS providers.
Will the CDAC providers have to put more than one code on their billing claim form that's replacing the W Code?	If a CDAC provider is authorized for both skilled and unskilled CDAC, then ISIS would show two authorized codes; the code for skilled and the code for unskilled. All providers must bill the same codes as approved in ISIS. These codes would be reflected on the NOD or the IME conversion notification report.
If we have a consumer's annual review in April do we want to change the CDAC to 15 minute units instead of hours now or wait for next annual?	CDAC 15 minute units are not affective until 7/1/13, so you could not use 15 minute units for months prior to July. If the member has daily CDAC, you can work with the provider and member to convert that to hourly CDAC now. Daily CDAC and hourly CDAC must all be converted to 15 minute units by 7/1/13.
When the new CDAC agreement is created will it actually print out appropriately and not in the middle of a category? Will the CDAC agreement be updated to reflect the 15 minute unit.?	How the CDAC agreement prints depends upon how much information is entered into the form. The form will be altered to reflect the 15 minute unit. Please continue to use the current version until the new is distributed. Distribution date for the revised agreement is not known at this time.
For a CDAC provider who is making the Max wage of $13.74 per hour, when that is divided into four 15 minute units the CDAC is actually going to be decreased in earning due to the number not dividing cleanly. Should the provider's rate be increased so that it can be divided evenly?	Per page 29 of the PPT, when converting a rate that has 3 or more digits past the decimal point, if the 3rd digit is 5 or higher the rate will be rounded up to the next higher penny. If the provider's rate is $13.74/hour , then the math gives $3.435/ 15 minutes. The IME will round to $3.44/15-mintues. This actually equates to a 2 cent raise. The new maximum rates per unit are included in the IAC rules for Chapter 79. CM/SW should not alter rates in order to have those rate divide evenly.
Will there be different CDAC rates for skilled and unskilled on the same client?	The rate for both will be the same, as it has always been. There is no plan to have separate rates for skilled and unskilled.
Will service documentation remain the same until the conversion on 7/1/13? Current CDAC agreements stays effective until 7/1?	Service documentation does not change after the conversion. All providers must document to support the service and time billed to the IME. Please refer to page 35 of the PPT. CDAC agreements with hourly services remain the same until the end of the plan, but with a notation of the change to 15 minute units. Only CDAC agreements for Daily and ALF must be changed for 7/1/13. A change in billing unit does to equate to a change in documentation.
What will the individual CDAC max rate be? Currently it is $13.74/hr.	For maximum unit or rate questions, please refer to the proposed rules for IAC Chapter 79.1. These rules can be found at http://www.dhs.state.ia.us/policyanalysis/RulesPages/Dockets.htm#search='rules docket'
When converting CDAC hours that have a PA already approved, will the PA be waved if there is no increase in total time/minutes? Will CM's have to go through the prior auth process all over with individual CDACs conversions?	Conversions done by the IME will not kick off milestones. So if the WPA process has been completed for a service then there will not be a milestone. Conversions done by CM/SW will kick off milestones; if theWPA process has been completed for a service then teh CM/SW needs to indicated that as a comment to the milestone. Medical Services will then push the milestone along.
Can there just be a letter created by IME that can be attached to the CDAC agreement versus the case manager making the notation on the plan?	Each organization can determine how they want to note the atypical conversion on their own plans. The IME will not mandate how this notation must look.
One slide says that new CDAC agreement are not needed except for assisted living and daily CDAC services and another slide says that new agreements must be created before 7/1/13. On the slide, it said new CDAC agreements need to be done by July 1st; you said that we just make note on them that the conversion takes place. We are confused- do we need a new CDAC agreement or not?	Page 48 was still referring to those CDAC plans for Daily or ALF monthly units. New CDAC agreements are not needed for members who currently have hourly CDAC units.
If the CDAC provider is paid $15 per hour, do we increase the rate so that it can be divided evenly by 4?	Providers can not be given rate increases; CM/SW must not alter any provider's rate to allow it to be converted evenly. The IME will convert rates based upon the rate currently in ISIS for each service for each member. FYI: $15.00 converts to $3.75 evenly.

If a CDAC provider agreement is approved for 10 hours per month, will the conversion make it 40 units (15 min units)	Yes, this is the example used on page 26 of the PPT. Multiply the current units by 4 to determine the number of 15 minute units.
Will CDAC agreement need to be re-written? Will providers fill out their Targeted Medical Claim form in 15 minute units?	Only daily CDAC and ALF CDAC agreements must be revised. Hourly agreements just need to have a note about the 15-minute conversion. CDAC providers will follow the same rounding rules as all other providers for 15 minute unit of service billing.
Very concerned about Assisted Living non conversion for CDAC. If the informational letter will not be sent out until shortly before 05/01/13 how can we begin to revise the agreements?	You and the assisted living providers have already been told that new CDAC agreements are needed, so there is no reason for you to wait for the next Informational Letter. The Informational Letter would be a reminder tof what you have already been told in the webinar and Informational Letters.
If the CDAC use is not consistent each month and one month they use 41 hourly units and then the next 3 months only use 3 units how do we do those CDAC agreements?	This issue is not related to the Atypical Conversion. But I am very concerned that the services provided to the member vary so widely. The member either needs or does not need 41 units monthly. I suggest that you speak to your supervisor and then contact Le Howland if you need further assistance.
For CDAC agreements, do we calculate a month as 5 weeks or 4?	4.33 weeks per month.
Will CDAC assisted living now require prior authorization since units will be specified rather than one unit?	PPT page 45 indicates that all CDAC agreements over 164 15-minute units monthly will require WPA review. Assisted living CDAC will use the same billing code as agency CDAC and will be treated the same in regards to WPA and maximum rates.
With the Assisted Living CDAC since it is changing from one unit to the 15 min if it is over the prior authorization maximum for July 1st will that need to be prior authorized July 1st or will it need to be prior authorized when plan expires?	PPT page 45 indicates that all CDAC agreements over 164 15-minute units monthly will require WPA review. The WPA review will be required at the time of the conversion and cannot be delayed until the plan expires. This is another reason why the IME is encouraging that CMs have conversations with the providers and members NOW.
Are ALF's allowed to provide skilled CDAC?	No, they are not allowed to provide skilled CDAC.
Will the annual CDAC training be held before 7/1/13?	General information about HCBS services will be included in the Medicaid Basics module this summer. There will not be a separate module for HCBS or CDAC.
Prevoc and Day Hab	
Currently we are able to authorize PreVoc services for someone to have 20 full days and 4 half day units. Will we be able to authorize full day and some hourly units? Or do we have to go to hourly to prevent any loss if a consumer needs to leave for an appt?	You can continue to use a combination of units, hourly and daily, dependent on the needs of the individual member. Per the proposed IAC rules revisions, only 4 hourly units can be billed for any day; at 4.25 hours the day is then billed as a full day. Plans can be flexible and can be altered through the case manager at the end of the month if there are variances.
I am a little confused why there is 15 minute units for Day Hab and only breaks prevoc into hourly units.	The time definition for each service is dictated to us by the standardized HCPC or CPT code list. The IME does not have the authority to alter the standardized code service definitions.
This is regarding the elimination of half day codes for Day Habitation and Pre Vocational Services. Last year two informational letters were sent (1155 & 1164) stating that providers can only bill one unit per day for Pre Vocational Services and Day Habilitation Services. Will this be rescinded?	With the elimination of the 1/2 day code, the provider can bill either the prevoc hourly or day hab 15 minutes units up to the maximum noted per day in the IAC or they can bill the daily code for that day. Keeping with the intention of the programs and the letters, a provider cannot bill both hourly, 15-minute or daily units for the same day.
The examples for conversions given in the presentation do not include these services. What is to be considered the number used? I.e. a half day is 1-4 hours and a full day is 4-8 hours. Where/who do we negotiate these rates with since County CPCs no longer negotiate these rates?	Proposed rules: Prevoc IAC 78.41(13) and 78.43(11): a unit of service is a full day (4.25 to 8 hours per day) or an hour (for up to 4 units per day). Day Hab IAC 78.41(14): a unit of service is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours per day.) Day hab 79.1(24) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours per day.) If the service is based upon fee schedule, then the provider sets their own rate. If the service is cost report based, then PCA sets the rate.
At what point is it considered a full day unit for both Pre-Voc and Day Hab versus a 15 minute unit or hour?	See answer immediately above.
How does a provider determine what constitutes hourly pre-voc or daily prevoc instead of 1/2 day pre-voc (or day hab also)? is it based on the number of hours the client is accessing the service? if so, what is the limit on the number of hours to fit each code?	See answer immediately above.
How does the 1/2 day hab convert? If a provider could charge 1 unit for 1/2 day hab if services were provided between 1-4 hours. Is the 1/2 day rate divided by 4 (4- 15 min units per hour) or divided by 16 (16 - 15 min units w/in 4 hrs)?	A 1/2 day rate is divided by 4 to determine an hourly rate or by 16 to determine a 15-minute rate. IME Provider Cost Audit will continue to load into ISIS those rates that they are responsible to load.
What about conversion of half day rates--how will you know how many hours are service are in the half day rate?	A 1/2 day rate is divided by 4 to determine an hourly rate or by 16 to determine a 15-minute rate. The number of units to be entered into ISIS should be discussed between the CM and provider for each individual member. It is not appropriate to automatically enter the same number of units for all members.
Do cost reports need to be completed for the new 15 minute or daily codes for prevoc and day hab to get new rates (for the 15 min and daily) compared to the 1/2 day?	Cost reports are not needed. A 1/2 day rate is divided by 4 to determine an hourly rate or by 16 to determine a 15-minute rate. IME Provider Cost Audit will continue to load into ISIS those rates that they are responsible to load.
We primarily use codes w1205, and w1207. At this point the conversion table tells us that the new code will be determined upon public notice of the rules. When will this information be available, and is there anything specific that we need to know now about these codes, or that we need to follow up with later?	The conversion charts says that the implementation date will be determined upon public notice of the rules. According to the chart, W1205 1/2 day hab does not have a conversion code. Also according to the chart, W1207 will convert to H2015. The implementation date of 7/1/13 has been communicated through 4 Informational Letters, this webinar, and this PPT.

If we are currently providing 1/2 day hab and convert to 15 min, will we need to have a new rate for 15 min units?	A 1/2 day rate is divided by 4 to determine an hourly rate or by 16 to determine a 15-minute rate. IME Provider Cost Audit will continue to load into ISIS those rates that they are responsible to load.
For habilitation services when we convert the unit will the new rate populate that goes with that new unit as rates populate in ISIS for habilitation?	The IME will enter into ISIS those rates that the IME has always been responsible for loading. See answer above for determination of those rates.
Is Pre-voc 1/2 day going to hourly or 15 minute units and how is the breakdown? For Pre-Voc and Habilitation 1/2 day conversion will it be billed hourly or in 15 minute units or both?	Proposed rules: Prevoc IAC 78.41(13) and 78.43(11): a unit of service is a full day (4.25 to 8 hours per day) or an hour (for up to 4 units per day. Day Hab IAC 78.41(14): a unit of service is 15 minutes(up to 16 units per day) or a full day (4.25 to 8 hours per day.) Day hab 79.1(24) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours per day.) Please also refer to the conversion chart on the IME website.
Is there a cap on the number of units that can be entered into ISIS for Day Hab or Pre-Voc?	The proposed IAC rules contain the maximums by limiting the codes/combinations that can be billed for one day. The IAC supersedes any programming that may or may not exist in ISIS. All providers, case managers, and service workers should understand IAC limitations and ensure that the ISIS plan does not exceed maximums.
How do we convert a half day rate to an hourly rate for day hab? Is this a negotiation per client with each case manager or is there a framework for standardizing half day conversions?	A 1/2 day rate is divided by 4 to determine an hourly rate or by 16 to determine a 15-minute rate. The number of units to be entered into ISIS should be discussed between the CM and provider for each individual member. It is not appropriate to automatically enter the same number of units for all members. IME Provider Cost Audit will continue to load into ISIS those rates that they are responsible to load.
Will the change of half day prevoc/day hab require an addendum to be completed by the TCM on the ICP to define scope of service provided?	Because each individual member's half day plan will look differently upon conversion, then there must be some notation in the service plan that describes the new plan. The CM, provider and member should all understand exactly how much service will be authorized under the conversion.
Info Letter 979 explains the rounding rules for Habilitation services. Any services that are less than 60 minutes are rounded up to 1 hourly unit. So, a 15 minute service would round up to 1 hourly unit. When going through the conversion, IME staff would assume that each hourly unit should be converted to 4 15-minute units. And the rate divided in 4. However, with the change, we will only be billing 1 15-minute unit rather than 4 (and our cost report is based on billing for the entire hour). Do you suggest we complete an ETP demonstrating what our actual unit rate would be, now that the rounding rules will impact how many units we will provide, and what rate is used?	IL 979 does not round as described in the question. IL 979 has this rounding explanation: *Add all the minutes provided for a day • When the total minutes for the day is less than 60, round up to one (1) whole unit • When the total minutes for the day is more than 60, divide the total by 60 to get the number of hours for the day. This should be rounded to the nearest whole unit, by rounding down for 1-30 minutes, and rounding up for 31-59 minutes. Services that remain an houly unit will retain this rounding rule plus incorporate the IAC rules for determining the unit to be billed based upon that day's service. Services that are billed with a 15 minute unit will now use the 15 minute rounding rules plus the IAC rules. The IME will convert the hourly rate to a 15 minute rate where applicable; no ETPs or revised cost reports are to be completed.
Per the Atypical Conversion chart, our codes for Habilitation Services of W1207, Brain Injured of W1421 and Intellectual Disability of W1311 all convert to H2015 on 7/1/13 with all also converting to unit time of 15 minutes. Currently the Habilitation is billed throughout the month since it is per day of service where the other two codes W1311 and W1421 are monthly. From the webinar training, we are assuming this part of billing does not change. However since they are all being converted to the same code is the NPI the factor that the system will use to recognized the daily billing of Habilitation?	The same code may be used for several different services. The provider number/NPI distinguishes waiver sevices from hab services. Providers will continue to bill with the same provider numbers as they have in the past. Provider must not interchange their provider numbers as those numbers are specific to either case management, habilitation state plan, or waiver services.
Unit rounding & Rate rounding	
I assume the 15 minute rounding rule means that you cannot carry over minutes to the next day? Is it acceptable to total minutes on each daily documentation sheet and then at month end total minutes from each day from the month and then divide by 15 just 1x when totaling up for billing?	Services billed as a 15 minute unit are added and rounded on a daily basis. In addition, those services such as adult day care, day hab, and prevoc also use each day's service provision time to determine the unit code to bill for that day's service. Extra minutes are not carried to the end of the month.
There is nothing in the PPT that gives you a rounding tool for hourly billing. Say you have someone come for 31 minutes can you bill for an hour of service or does it have to be an hour or nothing. Is there a rounding tool?	IL 979 discusses daily rounding for hourly units. Even though this IL was directed at habilitation providers, it is applicable to all HCBS providers billing an hourly unit. *Add all the minutes provided for a day • When the total minutes for the day is less than 60, round up to one (1) whole unit • When the total minutes for the day is more than 60, divide the total by 60 to get the number of hours for the day. This should be rounded to the nearest whole unit, by rounding down for 1-30 minutes, and rounding up for 31-59 minutes
We understand that the 15 minute increment units will be totaled and rounded daily, rather than totaled and rounded at the end of the month. Is this going to be true for hourly services as well?	Billable units are to be determined on a daily basis and are based upon the amount of service provided that day, except for Home based habilitation. Home based hab is the only service that is rounded on a monthly basis, as it has been. See IAC rule 79.1(24).
This question is regarding the rounding. For 15 minutes units of services you stated that the number of minutes are to be rounded daily. What about hourly services i.e. pre vocational. Are the hourly units to be rounded daily or at the end of the month?	See answer immediately above. Proposed rules: Prevoc IAC 78.41(13) and 78.43(11): a unit of service is a full day (4.25 to 8 hours per day) or an hour (for up to 4 units per day. Day Hab IAC 78.41(14): a unit of service is 15 minutes(up to 16 units per day) or a full day (4.25 to 8 hours per day.) Day hab 79.1(24) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours per day.)
What if the rounding causes the rate to go over the max?	Per page 29 of the PPT, the IME will not allow any monthly budget to exceed the waiver cap (unless an ETP was already granted for that purpose). If the converted rate causes the plan to exceed the budget, then the IME will reduce the rate by 1 cent. When creating new converted service rate maximums, the IME used the same rounding rule as will be applied to individual provider rates; therefore no individual provider's rate should exceed the IAC upper maximum.
Currently we can round up on the half hour, if changing to 15 minute units, when should we round up or down?	Please refer to pages 37-39 of the PPT for the discussion of the 15 minute rounding rules. These are also included in the IAC rules revisions.

What if a service provided lasts less than five minutes on a given day (like traveling to a person's home to make sure they've taken their medication)?	If only one service is provided in a day for a member and it is less than 8 minutes, then it is not billable. If there were other services provided to the member that day, then the provider would add them together and round according to the directions included on pages 37-39 of the PPT.
Does the rounding affect reimbursement?	Any affect on reimbursement could only be a cent per unit. Based upon the rounding rules on PPT page 29, the IME may need to round a rate that is not evenly divided.
What if the provider rate does not evenly divide by 4; for example $20.21.	Per PPT page 29, the IME will round up then the remainder after division is 5 or more. The rate of $20.21 becomes $5.052 which will round to $5.05.
Billing	
We currently send out our billing, in paper form, every week. Will we be able to continue that or will we have to start sending out billing monthly? We provide Habilitative services under code w1207 (soon to be H2016). Does the change to 15 minute units affect date span billing for habilitation? Or in other words, do I still have to bill each day separately unless by chance there are consecutive says with the same amount of units?	Because HCBS habilitation is billed one day per line, more than one claim form is payable by the IME per month. But, the IME advises all HCBS providers to bill after the end of the month because the CM/SW has the ability to alter a plan until the last day of that month. If billed prior to the end of the month, the provider may need to adjust the paid claim.
If you bill multiple lines per month, not one line per month, is it possible to bill mid-month or will the claim deny?	The IME advises all HCBS providers to bill after the end of the month because the CM/SW has the ability to alter a plan until the last day of that month. If billed prior to the end of the month, the provider may need to adjust the paid claim.
How does the conversion affect date span billing? Will we still have to bill each day separately? What would be the process if a provider wanted to change to daily billing versus monthly billing?	Nothing changes in regards to whether a service is billed one line per month or multiple lines per month. The determining factor is whether the service is a waiver service or a state plan service (TMC & Hab). No provider can choose to alter whether a service is billed one line per month or multiple lines per month. Any provider who tries to alter the billing cycle risks correct denial of claims.
What if we need to make an adjustment in for example, October, but its for June services?	Please refer to page 43 of the PPT. Services provided prior to 7/1/13 will continue to be billed and adjusted using the approved W code.
June 1-30 billing will be completed after 7/1/13 and we may have adjustments after 7/1 relating to prior months. Do we use old W-codes or new codes?	See answer immediately above.
Does the conversion affect the dummy V0001 diagnosis code allowed for waiver services?	Slide 41 of the webinar indicates that V00.01 is still the diagnosis used for electronic billing.
Modifiers	
I need clarification on a couple codes so I can proceed in re-coding our billing system in time for the changes to take place. Old code W2500, Respite, Waiver, HHA Specialized: the new code is listed as S5150. Old code W2501, Respite, Waiver, HHA, Basic: the new code is also listed as S5150.	The online conversion chart indicates that specialized respite uses code S5150 U3. Providers, case managers, and service workers must watch for the addition of modifiers which can be used to distinguish services. These modifiers are included in the conversion chart posted to the IME website and will be options through ISIS.
Code and Service Descriptions	
We are wondering about the service descriptions for the atypical codes that are being changed. Will the services that used to be RBSCL, SCL Daily and Home Based Hab all change to be commonly referred to as "Comprehensive Community Support Services"? Will this be changed in the administrative rules?	Look for use of modifiers to distinguish these services. Providers, case managers, and service workers must watch for the addition of modifiers which can be used to distinguish services. These modifiers are included in the conversion chart posted to the IME website and will be options through ISIS. The rules will continue to reflect the Iowa historical name for the service.
What does the home and vehicle modification services consist of?	Please refer to the Iowa Administrative Code Chapter 78 under the applicable waiver.
When codes are merged will service limits still apply? i.e. 62 meal units per month	All service limitations that are indicated in the IAC will still apply. When necessary, the number of units was increased by the conversion factor that that service (i.e.: hourly limits restated as 15-minute limits.)
For our Meal clients that receive 2 meals a day will we still be able to bill for both meals under the one code, separating the 31 days out on 2 lines?	The conversion chart posted to the IME website indicates there are 4 modifiers to be added to the meal code; one modifier for each meal plus liquid supplement. Each code/modifier combination can be billed up to the maximum number of units as entered into ISIS. When a modifier is added to a code, the code/modifier combination is billed on a separate line. The 62 meals per month restriction still applies.
Adult Day Care will also being going to 15 minute units correct? Is adult day care included in the new conversion codes?	Please refer to the conversion chart posted to the IME website.
Will chore remain half hour units?	Please refer to the conversion chart posted to the IME website.
Is SCL daily going to be billed in 15 minute increments as well?	Please refer to the conversion chart posted to the IME website.
How is tranportation being handled?	Conversions will be made to the new code using the existing units and rates. Due to a change in the definition of a trip (will be a one-way trip instead of a two way trip) CM/SW will at the time of a plan revision make sure the plan included the correct units and rates based upon the actual service to be provided.

For a service that has 2 different rates and did have multiple codes, such as individual and group rates, how will this convert to one code? Will the provider have to change their rate or will we enter the same service twice with 2 rates.	Individual and group respite or counseling are not converting to the same code; please refer to the conversion chart. With the conversion, there are 6 different codes to be used for respite: specialized individual, basic individual, group, facility, and 2 for camps. The IME will convert each plan based upon the rate already in ISIS for each member.
ISIS concerns	
Will the old W codes be removed from ISIS in the future?	The W codes will not be available for plans that begin on or after 7/1/13. On or about 4/30/13, the IME will end date all W codes in ISIS.
Will IME be requiring a QA or request from the case manager to make these changes in ISIS system?	Not sure what changes with Atypical conversion would require a QA. Remember that conversions should be completed by the end of July, therefore minimal additional QAs should be generated by the conversion process for July services while we are in the conversion process.
What is ISIS?	ISIS is the computer system used by case managers, service workers, and IME staff to create and track HCBS authorizations and Level of Care determinations. This system cannot be accessed by providers other than case managers.
I work for a home health agency - am I able to pull up the patient's ISIS records to inquire about their info?	This system cannot be accessed by providers other than case managers.
Will new NOD's be available if a case manager does want to send it to the providers?	The NOD generated through the ISIS service plan will accept and print modifiers. Case managers and service workers must send NODs for any service line that they convert. The IME will send each provider a report detailing the conversions made by the IME; no NOD will be issued for IME conversions.
Will you answer milestones to reapprove the plans or will we have to?	When the IME converts a line, no milestone will be triggered. If a CM/SW converts a line, then milestones can be triggered. The CM/SW is responsible for answering those milestones. If the purpose for the change is related to Atypical Conversion, then a comment should be added to the milestone identifying the change as atypical related.
Will milestones be triggered when the CM has to make adjustments to the conversions IME makes?	Any changes made to any plan for any reason by a CM/SW will kick off milestones. If the purpose for the change is related to Atypical Conversion, then a comment should be added to the milestone identifying the change as atypical related.
If IME does not get to all service plans in ISIS, this means the case manager has to change all plans, correct?	We will begin changing plans on May 1 and have until July 31 to finish. We have no doubt that we will be able to convert the plans within that 3 month time period. Remember, the IME will only convert those plans and lines that were authorized before 5/1/13.
Is IME altering the plans going to interfere with our ability to get into ISIS? Will it cause a problem if a Case Manager is working on a service plan in ISIS at the same time as IME is making conversions?	The IME will not deny ISIS access to CM/SW for the duration of this project. CM/SW will continue to have access to all ISIS plans unless the IME is in the process of converting the same plan that the CM/SW wants to touch. In that case, the CM/SW would just need to wait about 5 minutes for the IME to finish with that plan.
Will members' action plan show as not approved case plan on file for this service and therefore, decline and delay payment for service?	The IME will approve plans as the IME converts plans. Also, we are working for future dates of service, not current dates of service. We do not anticipate any decline or delay in payment as long as providers bill the correct conversion code, rate and units.
Can we enter new services effective 7-1-13 with new codes now? (for example the day hab or prevoc hourly). Can you enter in services that will start July 1st with the new codes before July 1st?	New codes can be entered into ISIS beginning 5/1/13 for the 7/1/13 begin date. For those services that the IME will not convert, then CM/SWs are encouraged to make those conversions early. CM/SWs can convert lines even before the IME touches a plan, there is no need to wait for IME action.
Miscellanous	
We have Waiver services for LPN Hourly (S9124 & T1031), RN Hourly (S9123 & T1030) & Basic Hourly (S9122) services. Can you please confirm that these services are NOT converting to a new code and that they are NOT converting to 15 minute units?	Only codes that begin with a "W" are affected by this conversion.
On the monthly funding waiver point: does this mean that we could have different rates for the same service for differing individuals?	The IME will be basing rate conversions by using the rate currently in each member's ISIS plan or by the rate entered into ISIS by Provider Cost Audit. There are many instances where the provider has rates that are individualized for the many members.
Are these changes for HCBS and Habilitation or HCBS only?	Habilitation is an HCBS program. So these conversion affect all HCBS services that use a billing code that begins with a "W": waiver and habilitation.
How is this conversion going to be effected by Magellan taking over Hab services? Is Magellan, rather then IME, going to be managing Habilitation services effective 7/1/13?	This conversion will not be affected by the transition of Habilitation. At this time, the details and timelines for implementation of the transition have not been finalized. Therefore the atypical conversion will proceed as described. As information regarding any transition of Habilitation is finalized, that information will be communicated.
Can you review what the atypical conversion chart notes as "UC required"? I am looking at the Job development and employer development support services that will go to T2018 and H2024? It also says the rate will be determined upon public notice of rules. Will this be in May?	The conversion charts says that the implementation date will be determined upon public notice of the rules. All rules have been noticed and have completed the public comment process. The implementation date of 7/1/13 has been recently communicated in 4 Informational Letters, this webinar, and this PPT. The conversion chart does not include rate information. The UC modifier is required in combination with the billing code for these services.
Can you list the 7 services that the CM/SW will have to do the conversions for again?	Daily CDAC, assisted living CDAC, 1/2 day prevoc, 1/2 day day hab, behavioral programming, nurse delegation, environmental modification.

What is left for providers, to do, to implement this process? For example, the 5010 conversion included many steps. Is there something that will be needed with this, or will it be more of an IME, Case manager thing?	IME staff will perform most of the tasks for the Atypical Conversion project. CM/SW will have some involvement, as outlined in the webinar and Informational Letters. Providers should be aware of the process and the upcoming changes to codes, rates, and units. Providers need to understand billing ramifications to make sure that cash flow is not adversely affected.
Will providers need new service plans from case managers authorizing the new code definitions effective 7.1.13?	CM/SW will note on their current service plans the necessary changes. Those changes will be communicated to providers as noted on PPT page 33. Only if there are significant changes is a new service plan warranted. Service plans should continue to use the historical service description used by the IME.
Will Exception to Policy letters still be honored until it's end date?	ETPs will be honored until their end dates, but there will still be conversions to the standardized codes, rates and units. If the ETP involves one of the services that must be converted by the case manager, then the discussions for that conversion should be undertaken soon so the CM can convert that service appropriately.
Will you be sharing that template with the service providers along with the case managers?	The IME can email the template to CA/SW because we have their correct email addresses. This is not the case with all providers. The IME will research if the template can be posted to the atypical webpage. If it can, then that location will be communicated in an Informational Letter.
When can we start using the new codes?	New codes can be entered into ISIS beginning 5/1/13 for a 7/1/13 effective date.
Who should the provider contact if the changes to codes/rates are incorrect? IME or CM/SW?	If the provider or CM/SW does not agree with the conversion made by the IME, then the CM/SW is responsible to revising the conversion. Providers should contact CM/SW for revisions.
If providers call CM's to alter ISIS based on utilization we have to keep in mind that that the CM plan would need to match and be addended too. This will be a lot of work if it happens monthly. Suggestions on how to make the NOD more flexible with units in both rate scenarios.	Not sure what you are asking here. Please email clarification to lhowlan@dhs.state.ia.us.
Electronic Claims	
How do you file electronic claims without the tenant signature?	The only HCBS service that can not be filed electronically is individual CDAC. All CDAC billed on paper must include the member's signature. But agency and Assisted Living CDAC can bill electronically. There is no mechanism for a member to sign an electronic claim.
Is there a PCACE update coming to allow service codes longer than 5 digits? Example: new code with modifier - will it fit in the service code field?	PC-ACE already accepts modifiers. No updates are needed to allow for modifiers.
Please repeat the information regarding free billing software.	Please contact IME Provider Services at 800-338-7909 or 515-256-4609 for assistance.
How can I get started billing waiver forms electronically?	If you want to use the free software supplied by the IME or if you are going to use another software then contact IME Provider Services at 800-338-7909 or 515-256-4609 for assistance and direction.
Is it possible to bill waiver services electronically versus the paper Claim for Targeted Medical Care form? Do we still need to use the Claim for Targeted Medical Care or can claims be sent electronically?	The only HCBS service that can not be filed electronically is individual CDAC. If you want to use the free software supplied by the IME or if you are going to use another software, contact IME Provider Services at 800-338-7909 or 515-256-4609 for assistance.
Targeted Case Management & Case Management	
BI waiver and Hab case management has the same code - do they still get billed under the separate NPIs they currently have? Will the case management still be authorized under "habilitation" and under "bi waiver"?	ISIS service authorization is tracked by HCBS program. Providers will still use the same NPI numbers that they have been using in the past. Habilitation case management and waiver case management may use the same code but would be billed with different NPI numbers.
BI waiver case management is billed the total number of units per month. Will this change to billing each day individually? Same for SCL W1311 ID waiver.	There is no change in regards to whether a service is billed one line per month or one line per day. Services billed through the waiver are billed one line on one claim per month. State plan services TCM and habilitation are billed one line per day.
IME will convert TCM authorizations? Will IME be doing the conversion for TCM codes in ISIS?	Yes.
Case management must calculate billable units daily. Why are we not allowed to bill mid month?	TCM technically can be billed mid-month, but the IME recommends against that practice due to possible changes in the ISIS plan. Case management through the elderly and BI waivers will only pay one claim per month as they are considered waiver services and not state plan services.
Why, when billing BI case mgmt, do we not bill like we do with regular TCM or Hab case mgmt?	TCM and Habilitation are state plan services. These can be billed multiple times per month, even through the IME recommends against that practice. Case management through the elderly and BI waivers will only pay one claim per month as these service are waiver services and not state plan services.
Is the task of reviewing the Service Plan in ISIS a billable activity?	Yes, the Case Management Billable Activities document includes entering service plans and specific service information into ISIS as a billable activity. The IME does not anticipate a large increase in CM billing per member unless the CM must work with the member/provider for line conversion decisions for prevoc, day hab, or CDAC.
If a Case Manager notices that IME made an error in a service plan, does the Case Manager change it themselves, or notify IME to change it?	The CM/SW must change any IME entry that the CM/SW does not agree with, whether the entry was an error or an IME choice.

You say CM/SW should send NOD's for changes they make in a timely manner. Does this start with the May 1 changes as we review for appropriateness or is this post July 1? What is an appropriate amount of time?	CM/SW should always be sending NODs in a timely manner. Timely NODs allow members and providers to know and understand any changes in services. IME preference is that an NOD is sent the same day that the plan is approved.
Will we as Case Mgrs, need to do an addendum to our ICP's to reflect the unit changes??	Each case management organization can determine how that organization wants to make note of atypical conversion to each member's plan.
Respite	
How will you handle ID respite? How will the respite be converted to keep with in the cap?	Units and rates will be converted just like all other conversions. The conversion should not cause a change in yearly amount of money spent for respite. Increased units X decreased rates should equal to the same yearly amount already in the plan. Case managers are responsible for monitoring the total dollars authorized for the plan year.
ID Waiver Respite, there is a yearly total of units. How will you know what number of units to convert for 7/1/13 thru the end of the waiver year?	ID waiver has a yearly maximum dollars to be spent for respite services. That maximum dollar does not change. The IME will convert respite lines following the same guidelines used for other services. Case managers are responsible for monitoring the total dollars authorized for the plan year.
Why was the respite conversion not discussed?	The webinar did not speak about every HCBS service, but used some services as examples. There will be nothing unique about respite conversion.
For respite services using the old W codes there are different rates. For example ID Respite, BI Respite, and Ill and Hand Respite. How are you going to convert all respites to one code and one rate?	The IME will convert each member's plan individually, using the rate that already exists in that plan for the service. The IME will not be creating one rate to use for all of a provider's members nor will the IME be using one member's rated information for another member's service plan.
Change Notification Report & CM/SW email	
Can the provider request who receives the report for providers of the changes made in ISIS? The notifications to providers of changes will these be mailed or emailed? Who will the member specific documentation of change be sent to? As a provider, can we request a specific contact to receive those notifications?	The report will be mailed to the address for correspondence that the provider has on file with the IME Provider Enrollment Unit. These notifications will not be emailed.
Does the report mailed to providers of changes list each change separately or just say which members have been changed?	The report mailed to the providers will list each member by name and SID and the conversion information for that member: code, units, rate etc.
Can we get a sample of the report that the providers will receive so that we can explore how we could import this information into our computer systems?	We have not yet created the report. We will take your request under consideration.

The handout says providers notified by EMAIL that changes have been entered. Are you doing that for ALL 33000 cases?	PPT page 32 states that the IME will email to CM/SW the last name range that has been converted. PPT page 33 states the IME will mail a report to each provider of their own clients who have been converted. These are two separate processes with separate purposes. The list to the CM/SW is so they can review each of their clients in ISIS to confirm correct conversion. The list to each provider is so they know what code, units and rates are now entered into ISIS for each of their members.
The notification to all case managers and services workers is that by consumer alphabetically or by case manager alphabetically?	CM/SW will all receive an identical, short email. That email will indicate the first several letters of the last names of the members the IME converted that week. For example: week 1 maybe Aa…. through Ca…. Week 2 maybe Ca…. through Fe…..
Will agencies need to have a new NOD from the case manager if you guys (IME) do the revisions in ISIS for plans after July 1?	PPT page 33 indicates that the plans converted by the IME will not have a NOD sent. Instead, the IME will send a report to each provider outlining the changes made for their own clients.
CCO	
CDAC agreements when converted to CCO- Who will do the agreement and change version to 15 minutes or will it happen automatically in the ISIS system? Will you be converting CCO hourly rates to the 15 rates?	The IME will alter the CCO agreements to use the converted codes, units and rates.

How will CCO work?	CCO will convert the same way that the rest of HCBS converts. We do not anticipate anything unique for CCO.

How will this affect CCO plans? Shouldn't those with CCO plans start changing their budgets early so everything gets approved timely? Is there a code for CCO?	We are aware that all CCO conversions for July must be done early in June in order for the plans to be in place. IME will be running additional reports in June to make sure all CCO plans that were authorized by 5/1/13 will be converted timely. CCO plans approved after 5/1/13 must be converted by CM/SW.
Does the CDAC agreement still need to be completed when a person is using CCO for CDAC approval?	Yes, there is no change in the requirement of the CDAC agreement.